

**Iowa Department of Inspections and Appeals
Health Facilities Division
Citation**

Citation Number: 6638	Amended Citation – Fine amount reduced to 35% to \$2,600.00 on January 19, 2018. Pursuant to Iowa Code Section 135C.43A	Date: September 5, 2017		
Facility Name: Sunnycrest Manor		Survey Dates: August 21-22, 2017		
Facility Address/City/State/Zip 2375 Roosevelt Street Dubuque, Iowa 52001				
	DS			
Rule or Code Section	Nature of Violation	Class	Fine Amount	Correction date

58.19(2)a	<p>481-58.19(135C) Required nursing services for residents. The resident shall receive and the facility shall provide, as appropriate, the following required nursing services under the 24-hour direction of qualified nurses with ancillary coverage as set forth in these rules:</p> <p>58.19(2) Medication and treatment</p> <p>a. Administration of all medications as ordered by the physician including oral, instillations, topical, injectable (to be injected by a registered nurse or licensed practical nurse only); (I,II).</p> <p>DESCRIPTION:</p> <p>Based on record review and staff interviews, the facility failed to administer medications as ordered by the physician which resulted in a significant medication error and hospitalization (Resident #3). The sample consisted of 9 residents and the facility reported a census of 76 residents.</p> <p>Findings include:</p> <p>Review of the August 2017 Medication Administration Record, identified Resident #3 had diagnoses which included eating disorder, obsessive compulsive disorder and chronic</p>	I	\$4,000	Upon Receipt
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Facility Administrator

Date

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	<p>obstructive pulmonary disease (COPD).</p> <p>Review of the Minimum Data Set (MDS) assessment form dated 08-09-2017 indicated Resident #3 scored 13 (of 15) points on the Brief Interview for Mental Status (BIMS). A score of 13-15 reflected no cognitive impairment. According to the facility plan of care, Resident #3 exhibited long term and short term memory loss and periods of confusion. The MDS assessment described Resident #3 as being able to transfer and ambulate independently.</p> <p>According to record review, Resident # 4 had diagnoses which included paranoid schizophrenia, anxiety, obsessive compulsive disorder, postural kyphosis and osteoporosis. Review of the MDS dated 07-27-17 Resident #4 scored 12 (of 15) points on the BIMS indicating mild cognitive decline. According to the facility plan of care Resident #4 transferred and ambulated independently.</p> <p>During an interview on 08-21-2017 at 12:28 p.m. Staff A stated she worked the overnight shift on 8/15/17 from 10:00 p.m. to 6:30 p.m. to 6:30 a.m. on 08/16/2017. Staff A stated about 5:20/5:30 a.m. (on 08/16/2017) she observed Resident #3 in the solarium seated at a table. Staff A stated a nursing assistant informed her that Resident #4</p>			
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	<p>was also in the solarium resting in a recliner. Staff A stated she dispensed the morning medications for both Resident # 3 and # 4. Staff A stated she took both medication cups to the solarium and placed one cup in front of Resident #3. Staff gave Resident #4 a dietary supplement and then returned to Resident #3 to administer a treatment. Staff A then returned to the medication cart, placing the remaining medication cup on the cart. At that time Staff A stated she recognized the medication cup appeared to contain Resident #3's medications. Staff A stated she then started doubting herself on which medications Resident #3 had consumed. She stated she destroyed the unused medications and reported the possible error to her supervisor. Review of the medication list identified Resident #3 received the following medications belonging to Resident #4: Synthroid 50 mcg (thyroid medication), MAPAP 325 milligrams (analgesic), Buspar 15 milligrams (anti-anxiety), Clozapine 100 milligrams 3 tablets (antipsychotic), Colace 100 milligrams (stool softener), Lorazepam 0.5 milligrams (antianxiety), Zyprexa 15 milligrams (antipsychotic), Artane 2 milligrams (for Parkinson's disease and helps with stiffness, tremors).</p> <p>According to documentation in the Nurse's Notes dated 08-16-2017 at 5:40 a.m. Resident #3 was observed (by a resident friend) to drop his/her</p>			
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	<p>pop bottle and all of a sudden became not him/herself. Documentation at 5:55 a.m. indicated staff alerted Resident #3's physician and received orders to transfer Resident #3 to the emergency room. At that time Resident #3's condition remained unchanged.</p> <p>According to the hospital history and physical report, another resident's medications were accidentally given at perhaps 6:00 this morning. Resident had "slurred speech, alteration in mental status, can respond to stimulation but not able to put things together." The notation also indicated the Resident #3 "is likely to become more lethargic in the next several hours given the sedative effects of the medications given and fairly long half-life. (Resident #3) has chronic underlying hypoxic respiratory failure with COPD, sleep apnea, pulmonary fibrosis and is at high risk for respiratory failure. For safety, he/she is intubated in the Emergency Department." The note indicated the resident in serious condition.</p> <p>According to documentation in the Nurse's Notes dated 08-19-2017, Resident #3 returned to the facility at 1:55 p.m. Resident #3 was alert and expressed happy to be back [to the facility].</p> <p>Staff A's medication administration pass was audited. Staff A did not have a history of</p>			
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	<p>medication errors.</p> <p>The Administrator provided a typed response that all nurses and certified medical assistants would have medication pass audits by 9/15/17. The audit would be repeated in the next 3 to 6 months or until all the nurses and certified nursing assistants have been again audited to assure compliance with facility standards of practice.</p> <p>FACILITY RESPONSE:</p>			
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